Appendix B

DIVISION OF DEVELOPMENTAL SERVICES

CRITICAL INCIDENT REPORT FOR RESTRAINT

NAME OF PERSON: _____

NAME OF AGENCY: _____ ☐ *Check if self-managing*

NAME OF GUARDIAN: _____

NAME OF PERSON REPORTING: _____

DATE OF RESTRAINT: _____ **TIME:** _____

LOCATION: _____

TYPE OF RESTRAINT: ☐ Physical ☐ Chemical ☐ Mechanical ☐ Other

NAME OF RESTRAINT: _____

(Name of drug or restraint used.)

NAME OF PERSON UTILIZING RESTRAINT: _____

DESCRIPTION OF INCIDENT: *(Include why restraint was needed and alternatives tried.)*

_____

_____

_____

_____

_____

_____

HOW LONG DID THE RESTRAINT LAST? _____

NAMES OF ANYONE ELSE PRESENT: _____

DID INJURY TO ANYONE RESULT? *(Describe)* _____

_____

CAN YOU THINK OF ANYTHING THAT LED UP TO THE INCIDENT? _____

_____

HOW WAS THE PERSON AFFECTED? _____

_____

HOW DID YOU FOLLOW UP WITH THE PERSON WHEN THE INCIDENT WAS OVER?

_____

_____

Over

WHO WAS NOTIFIED ABOUT THIS INCIDENT? ☐Supervisor/Case Manager ☐ Guardian

☐ Agency Director ☐ Division of Developmental Services ☐ Other _____

Supervisor's/Case Manager's Comments

NAME: _____

WHAT DO YOU THINK CAUSED THIS INCIDENT? _____

_____

_____

DOES THE PERSON HAVE A SUPPORT PLAN THAT INCLUDES USE OF THIS RESTRAINT?
☐ Yes ☐ No

IS FOLLOW-UP NEEDED? ☐ Yes ☐ No - *If yes, please describe follow-up that is needed:*

_____

_____

OTHER THAN THIS REVIEW, IS THERE A PROCESS FOR REVIEWING THIS INCIDENT TO AVOID FUTURE OCCURRENCES? ☐ Yes ☐ No *Describe:*_____

_____

_____

_____